Form 130 Revised 11/01

STATE OF UTAH - LABOR COMMISSION
Division of Industrial Accidents
160 East 300 South, 3rd Floor, P. O. Box 146610
Salt Lake City, UT 84114-6610

INSURANCE COMPANY'S AND SELF-INSURER'S FINAL REPORT OF INJURY AND STATEMENT OF TOTAL LOSSES

INSTRUCTIONS: This final report MUST BE FILED as soon as possible, but not later than thirty (30) days after final payments are made in all workers' compensation cases. (Form 219 is also filed in all cases of permanent impairment.) List ALL medical payments made, even if reimbursed by the Employers' Reinsurance Fund. This form is to be filed when an Order is entered.

Employer's Name: _____

Employer's Address: _____ Zip: _____

Employee's Name: _____ Date of Injury: _____

Employee's Social Security Number: _____

When was employee physically able to return to work?_____

Light Duty/Part-time: (Indicate Period of Time)_____ Full duty: _____

Actual **number of days** injured was absent from work:_____

PAYMENTS

Temporary Total for:	_____	weeks at $_____	for a total of	$_____
Temporary Partial:	_____	weeks at $_____	for a total of	$_____
Survivor Benefits for:	_____	weeks at $_____	for a total of	$_____
		Medical:		$_____
		Vocational Rehabilitation:		$_____
		Travel Expenses and per diem:		$_____

Date of this report: _____ **TOTAL:** $_____

_____ Insurance Company

_____ Adjusting Firm

_____ Printed Name of Adjuster

_____ Signature of Adjuster

_____ Adjuster's Phone Number

_____ Adjuster's Mailing Address

Mail the original of this form to the employee and a copy to the Labor Commission